

Dan's Talking Points Memo



COUN 231 • H. Dan Smith, EdD, MFT
Wilcoxon, Remley, Gladding, & Huber; Chapter 3
(for discussion on September 17, 2009)

1. Know what Brandt (1959) thinks about moral decisions; "they involve the use of words known as moral predicates such as 'ought,' 'should,' 'right,' 'good,' etc., and their opposites." (p. 42)
2. Per Herlihy and Corey (1996), "Ethical thinking is not simply a matter of black and white categorization." I would have to agree with this notion. (p. 42)
3. According to the Daubners (1970), "ethics addresses principles that ought to govern human conduct rather than those that often do govern it." Unfortunately, too many people in our profession do *what they want to do* for themselves rather than *do what is right* for the client. (p. 42)
4. Get a feel from the authors on the distinction between "ethical behavior" and "moral conduct." While they have similar characteristics and outcomes, the motivations may be slightly different. (p. 42)
5. Mowrer (1967) states that the terms "morals" and "ethics" are frequently used interchangeably, but he notes that "morals definitively refers to the goodness or badness of behavior, whereas ethics represents an objective inquiry." (p. 42)
6. According to Jones, et al. (1977), ethics are primarily concerned with "helping the therapist decide what is right, not with getting *clients* to do what is believed to be right." Having said this, I can think of many times where doing the "ethical thing" did not cause the client to do the "right thing," AND other times when the "ethical thing" could actually be perceived as hurting a client (at least from some viewpoints). What do you think? (p. 43)
7. Understand and articulate the distinction between *virtue ethics* and *principle ethics*. "Who shall I be?" v. "What shall I do?" (p. 43)
8. What is the moral/ethical distinction between what is *permitted* and what is *preferred*? If what is permitted is both legal and ethical, why should we seek what is preferred? Or does it really matter?
9. What about autonomy, beneficence, nonmaleficence, justice, and fidelity? (Beauchamp & Childress). Be able to discuss these terms. (p. 45)
10. Which branch of the helping professions was first with a code of ethics? When? (p. 45)
11. According to Van Hoose and Kottler (1985), what are the "three protections" provided by codes of ethics? (p. 45-46)

12. While I've never really thought about it in these exact terms, this class is all about "socialization" and "indoctrination" as a Marriage and Family Therapist. (p. 46)
13. Be able to distinguish between *formal* and *informal* discipline for those who behave in contradiction to published ethical standards. Examples of each, please. (p. 46)
14. Codes of ethics tend to emanate from professional societies rather than governmental organizations (which is the source of "laws"). What clout does a professional society have to enforce their codes? What if I'm not a member of that particular society? Do the codes then pertain to me? (p. 46)
15. Hmm. Many professional societies forbid "sexual intimacies" with current clients. At least one forbids sexual intimacies with current *or* former clients for a duration of time and with conditions. Do you know CAMFT's ethical position? What about California law?
16. Ethical codes do not propose to "recommend specific behaviors in limited situations." Why not? Wouldn't life be easier if they were more explicit? Do you understand the concept that more words equals less utility? What do Stude and McKelvey (1979) say about this in their inset on page 48?
17. Know Kidder's three bases for ethical decision-making. UNDERSTAND them! (p. 48)
18. Know Kitchener's four-process model of ethical decision making: 1) interpreting a situation as requiring an ethical decision, 2) formulating an ethical course of action, 3) integrating personal and professional values, and 4) implementing an action plan. (p. 48)
19. According to Welfel and Lipsitz (1984), about what percentage of mental health practitioners are insensitive to the ethical dimensions of their work? (p. 49)
20. I like the idea on page 50 whereas several authors have stated that when "principles are in conflict, ethical actions should emanate either from what one would want for oneself or significant others in the same circumstances or from what would produce the least amount of avoidable harm."
21. Have a familiarity with the Keith-Spiegel and Koocher (1998) 8-step model of ethical decision making. This model has lots of practical implications for MFTs. (p. 51-53)
22. Note how the various codes of ethics underscore nondiscrimination and respect for diversity. (p. 54-55)
23. Also note how the various codes recognize that we have our unique values and personal preferences as therapists and how our therapeutic behaviors must be examined in the light of these intrapersonal distinctions. All the codes call upon us to seek responsible and respectful decision making processes when values and preference conflicts arise. They will, trust me! (p. 55-57)
24. Big discussion point: Recognition that our first priority is to promote the welfare of the client. What criteria should be used to determine whether there is benefit coming from our interaction? What if a client thinks they are growing, but we don't? What about the client who is using the relationship for companionship v. therapeutic change? (p. 58)

25. All codes of ethics tend to reflect on "scope of practice" (a phrase that will be used a lot in this class). Who determines "scope of practice," and why is this important? (related to Benitez text)
26. Is "Due Care" (page 59-62) the same as "Scope of Competence"?
27. What should be done when it is determined that a therapist is impaired? List a few of the more salient impairments? How about some less obvious impairments that may be equally detrimental? (p. 62-63)
28. Confidentiality - Privileged Communication - Privacy. Pages 64 to 70. Digest this stuff. It is the basis for what follows.
29. Know the difference between "confidentiality" and "privilege." This is complicated stuff, but it MUST be understood for you to be a safe practitioner.
30. Know that the term "privilege" is a legal distinction that is a factor for us who practice in California. Please note the table of "exceptions to unwaived rights to privileged communication" on page 66. While some of these are applicable to California, others are not. Also, there are exceptions to privilege in this state that are not listed. We will discuss.
31. Confidentiality is an "out of the courtroom" reference to our keeping material undisclosed. We say that we are observing the principle of confidentiality, but it is the client who has control in the case of privilege. Confusing.
32. Some states are a bit flaky with their privilege laws. Virginia is noted for having a privilege statute, but if the disclosure is made before a 3rd party (in this case a spouse), privilege is not assured. In California, the "family" or the "couple" is the client, and the same rules apply where privilege is concerned (per CAMFT attorneys).
33. On pages 67 and 68, the authors do a great job of listing some of the dos and don'ts where court-compelled disclosure is desired or required. We will talk a lot about subpoenas, dealing with attorneys, CAMFT support, support by CPH and Associates, etc. This is important stuff for you to know as BIG mistakes can be made here!
34. "Privacy" is an important construct that encompasses confidentiality and privilege; it seems to be used more frequently with reference to HIPAA (Health Insurance Portability and Accountability Act of 1996) as it applies to the methods by which client information is handled in the office and to communicate with outside payment, referral, or support sources. There are lots of problems and considerable confusion around all of this. I'll have more to say about HIPAA in a few weeks. (p. 68-70)
35. One change in this book from the last edition is the use of the term, "multilayered nature of the relationship." I think they are trying to communicate that therapy does not exist merely between the therapist and client; various other institutions, demands, laws, etc., make the relationship more complex than it might seem at first glance. (p. 70)

36. "Duty to Protect." This will be a topic of ongoing discussion throughout the semester. At this juncture, one's "duty to protect" hinges on one's ability to predict violence. Wow, this is difficult. As a therapist, you are not required to be clairvoyant, but you are required to behave in a manner consistent with others in your profession when faced with similar circumstances. Corey et al., on page 70, has a set of procedures when assessing whether a client poses a serious danger to others. You might dog-ear this page for future reference!
37. On page 71, the authors discuss a "duty to report" (e.g., child and elder abuse, etc.) and we'll also work hard on "duty to warn" (e.g., Tarasoff). Just read this over and we'll follow-up later. Also, this area touches on "on-line therapy." More to follow on this, too.
38. What is the distinction between *secrecy* and *privacy*? The authors state, "therapists who keep secrets collude with secreteholders and thus betray the trust of unaware members while enhancing the potentially destructive power of secreteholders." What do you think?
39. Informed consent. What is the meaning and purpose of "informed consent"? Why is it an issue? How can "informed consent" save your hide when faced with a malpractice lawsuit? What do you think about the therapeutic contract as presented on pages 74 and 75? What are the hazards of contracts?
40. In conjunction with other documents for assuring "informed consent," the authors introduce the notion of "professional disclosure statements." What do you think about the example given on pages 78-79?
41. And finally, the authors delve into "multiple client considerations." Working with families is really different than working with individuals. Here we have to consider whether helping one will negatively affect another, or whether the general good of the family might be harmful to one member. There are considerations that we rarely ponder on an ongoing basis in individual work. (p. 80-84)